Hawaii Dept. of Health, Office of Health Care Assuranc

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	12G038	A. BUILDING: _____ B. WING _____	01/07/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ARC OF MAUI - HALE KANALOA	450-B KANALOA AVENUE KAHULUI, HI 96732

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
9 005	11-99-4(a) ACTIVE TREATMENT PROGRAM A plan of treatment shall be developed and implemented for each resident in order to help the residents function at their greatest physical, intellectual, social, emotional, and vocational level. This Statute is not met as evidenced by: Based on observation, interview, and record review, the facility did not ensure that the individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including but not limited to self-feeding) until it has been demonstrated that the client is developmentally incapable of acquiring them for Client #3. Findings include: Client #3 experienced a decline in his self help skills related to a neck fracture, however, there has been no update or new individualized self-feeding plan formulated for him. Observation of the dinner meal on the evening of 1/5/15 had Client #3 sitting in his wheelchair approximately 2 feet away from the dining room table. A caregiving staff #1 stood next to the wheelchair and held the client's dinner plate in one hand while using her other hand to assist the client in using his built up fork. She placed her hand over his hand which held the fork, then assisted him in picking up the food and bringing it up to his mouth. There was some difficulty in this process to pick up food as the caregiver could not stabilize the plate in which she held in her other hand. The staff in the home was asked whether this was the method in which the client ate his meals, and whether a bedside table was utilized for him as was done during the earlier lunch	9 005	**Reference Tag ID 9 005** **11-99-4 (a) ACTIVE TREATMENT PROGRAM** **The facility did not ensure that the individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to self-feeding) until it has been demonstrated that the client is developmentally incapable of acquiring them for Client #3.** To correct this issue, a formal Habilitation Program for *Feeding* was developed. Although, the Health & Safety and Mealtime Assessment for Client #3 provided staff with direction to safely assist the client during the feeding process, it did not provide adequate instruction to ensure consistent practices. This new *Feeding* program provides specific instruction for staff to follow and the associated data documentation required to assess progress toward program goals. All staff in the Residence and Day Program was trained on the new program which was implemented immediately.	2/4/15

Office of Health Care Assurance
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Valerie Sly — Program Supervisor — 2/4/15

c: JS 2/9/15 D

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9 005	Continued From page 1 meal. Caregiver #1 answered that she wasn't sure as she was not a regular staff in this home. The other two evening staff members replied that the bedside table is used for this client at meals. The bedside table was behind the client's wheelchair, and the staff brought it out for the client. The following morning on 1/6/15 during the breakfast meal, the client's meal was placed on the bedside table, which had a foam mat on the middle portion of the table. The day shift staff reported that the foam mat is to stabilize the built up plate that the client uses at meals. During breakfast, the staff confirmed that the method they use is not hand over hand with the client, but instead placing their hand near his elbow to stabilize and strengthen his hand so that he may use the fork effectively. During record review on the morning of 1/6/15 the individualized program plan for self-feeding could not be located. Subsequent interviews with the case manager on that morning confirmed that an individualized plan for self feeding had not been done.	9 005	To ensure no other clients were affected by this issue, all other client's Individual Program Plans were reviewed and determined to be adequate. A systematic change to prevent recurrence is the development of a new protocol: *Habilitation Skills Checklist.* This checklist includes a quick reference guide of the required areas of habilitation for training in personal skills and provides a way to document compliance toward the requirements. This information is a handy reference guide for the ICF Case Manager to evaluate whether the client's current Individual Program Plan is in accordance with the requirements. This protocol will be implemented at the time of the client's Individual Program Plan (IPP) review and quarterly plan review or when there is a significant change in the client's condition. The checklist will be located in the client chart.	
9 071	11-99-7(k) CONSTRUCTION REQUIREMENTS The minimum clear width of a corridor shall be thirty-six inches, except that corridors serving one or more non-ambulatory or semi-ambulatory residents shall be not less than forty-four inches in width. This Statute is not met as evidenced by: Based on observations and staff interview, the facility did not ensure the minimum clear width of a corridor shall be thirty-six inches except that	9 071	To monitor this corrective action, the ICF Case Manager will now include this checklist as part of the Case Manager's current Quality Assurance (QA) quarterly report. This QA report will be reviewed by the Program Supervisor, documented in the ICF Program QA report and located in the QA binder.	

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9 071	Continued From page 2 corridors serving one or more non-ambulatory or semi-ambulatory residents shall be not less than forty-four inches in width. Findings include: Observations during the survey period from 1/5/15 through 1/7/15, noted 3 of the 5 residents living in the home use wheelchairs all or part of the time. The width of the hallway was about 4 tiles or approximately forty-eight inches wide. This was validated during interview with the Program Supervisor on the morning of 1/6/15.	9 071	**Reference Tag ID 9 107** **11-99-11 (b) RESIDENT DAILY LIVING CARE AND TRAINING** **The facility did not ensure that they provided each employee with initial and continuing training that enables the employee to perform his or her duties effectively and competently.** 1) Self- feeding for Client #3. (See Reference Tag ID 9 005 above) 2) Follow Health & Safety instructions regarding height of hospital bed for Client #3: The hospital bed for Client #3 has bed rails to prevent the client from falling out of bed and the client does not have the physical ability to climb out of bed. The bed is electric at the head and foot, but the body of the bed is raised and lowered with a manual crank. The Health & Safety for Client #3 was reviewed. It states: "The bed is to be raised to staff waist level for any incontinent care that is done while client is in bed. Lower the bed to its lowest position when care is completed." After reviewing the issue with staff, several staff stated that they kept the bed in the high position after personal care, for purposes of allowing the client to look out the window. In addition, staff stated	2/4/15
9 107	11-99-11(b) RESIDENT DAILY LIVING CARE AND TRAINING The facility staff shall participate in appropriate activities relating to the care and development of the residents including training in activities of daily living and the development of self-help and social skills. This Statute is not met as evidenced by: Based on observation, interviews, and record reviews, the facility did not ensure that they provided each employee with initial and continuing training that enables the employee to perform his or her duties effectively and competently. Findings include: Cross reference to W242, W339, W368 and W369. The employees were not effectively trained to assist in:	9 107		

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9 107	Continued From page 3 1) self-feeding for Client #3; 2) follow health and safety instructions regarding height of hospital bed for Client #3; 3) reporting medication order discrepancies and following physician orders; and 4) implementing the health and safety instructions for flushing the G-tube after medication administration.	9 107	that cranking the bed up and down takes some effort. To correct this issue, the Health & Safety for Client #3 was revised. In addition to the current instruction regarding returning the bed to its lowest position after personal care, it now includes the following: "When the client is awake and wants to look out the window while in bed, staff may leave the bed raised, but must remain in the room with the client as long as the bed is elevated."	
9 172	11-99-20(a) NURSING SERVICES Each facility shall provide nursing services in order to meet the nursing needs of residents. This Statute is not met as evidenced by: Based on observation, interview, and record review, the facility did not ensure that nursing services must include other nursing care as identified by client needs for 2 clients. (Clients #2 and #3). Findings include: 1) Cross reference to W368. The facility did not ensure that the system for drug administration assured that all drugs are administered without error. There were two errors. Observation during medication administration on the morning of 1/6/15 had the licensed nurse administering medications to Client #2 through a G-tube. The label on one of the medications administered was for Clindamycin HCL 150 mg., 2 capsules (300mg), PO. A second medication given was Clonidine HCL 0.1 mg po tid., which she crushed and placed in the warm water. She then administered three medications through the G-Tube.	9 172	In addition, the bed crank was inspected by the agency maintenance person and was determined not to be in proper working order. The service provider for the hospital bed, Gammie Homecare, was contacted and the crank assembly was replaced. However, staff maintained that the bed crank still takes effort. To ensure no other clients were affected, the correct implementation of the Health & Safety of the other resident in the home with a similar hospital bed and Health & Safety protocol regarding the bed height was reviewed and no issues were identified. In addition, the bed crank was determined to be in good working order. A systematic change to prevent recurrence is the training of all staff in	

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9 107	Continued From page 3 1) self-feeding for Client #3; 2) follow health and safety instructions regarding height of hospital bed for Client #3; 3) reporting medication order discrepancies and following physician orders; and 4) implementing the health and safety instructions for flushing the G-tube after medication administration.	9 107	the Residence and the Day Program on the revised Health & Safety for Client #3. In addition, the hospital beds for both clients in the home were converted to *all electric*. The cost of the conversions was not covered by Medicaid, however, this will assist staff to raise and lower the hospital beds requiring minimal effort and without having to use a manual crank. To monitor this corrective action, the Resident Manager will observe and document three (3) times weekly for a period of two (2) months, the correct implementation of the Health & Safety's for those clients in the home with hospital beds. Documentation will be reviewed by the Program Supervisor and located in the QA binder.	
9 172	11-99-20(a) NURSING SERVICES Each facility shall provide nursing services in order to meet the nursing needs of residents. This Statute is not met as evidenced by: Based on observation, interview, and record review, the facility did not ensure that nursing services must include other nursing care as identified by client needs for 2 clients. (Clients #2 and #3). Findings include: 1) Cross reference to W368. The facility did not ensure that the system for drug administration assured that all drugs are administered without error. There were two errors. Observation during medication administration on the morning of 1/6/15 had the licensed nurse administering medications to Client #2 through a G-tube. The label on one of the medications administered was for Clindamycin HCL 150 mg., 2 capsules (300mg), PO. A second medication given was Clonidine HCL 0.1 mg po tid., which she crushed and placed in the warm water. She then administered three medications through the G-Tube.	9 172	3) Reporting medication order discrepancies and following physician orders for one client: To correct this issue, a thorough review of the client's medications was discussed with the agency RN. The client returned from the hospital in August, 2014, with a prescription for a Clonidine Patch. Her insurance only paid for a one month supply, so the pharmacist contacted the client's Cardiologist who changed the patch to 0.1mg tab PO TID even though the Dr.	

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9 107	Continued From page 3 1) self-feeding for Client #3; 2) follow health and safety instructions regarding height of hospital bed for Client #3; 3) reporting medication order discrepancies and following physician orders; and 4) implementing the health and safety instructions for flushing the G-tube after medication administration.	9 107	was fully aware the client had a G-tube. It was incorrectly documented on the Medication Administration Record (MAR), the Physician's Orders and the Blister-Pak. The discrepancy was never identified by the agency RN, the pharmacist or staff, but the medication was always administered via G-tube. Clindamycin 150mg – 2 capsules (300mg) was ordered in January, 2015, after the client was seen at an "after-hours" clinic on a Friday evening. The order was correct on the MAR since the agency RN had instructed staff what to write over the phone after the medication was received on the following Saturday morning, but the pharmacy dispensed the label for the Blister-Pak incorrectly (PO), and the Physician's Order was for (PO/GT). The discrepancy was never identified by the agency RN, the pharmacist or staff, but the medication was always administered via G-tube. Staff was implementing the correct route for the client's medications which was *via G-tube*. However, the discrepancies between the MAR, the Physician's Orders and the Blister-Paks were not identified. Staff was not following the "Five Rights" of medication administration and did not report the discrepancies.	
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9 107	Continued From page 3 1) self-feeding for Client #3; 2) follow health and safety instructions regarding height of hospital bed for Client #3; 3) reporting medication order discrepancies and following physician orders; and 4) implementing the health and safety instructions for flushing the G-tube after medication administration.	9 107	A review of all the client's medications identified one other discrepancy: Levothyroxine. This medication was a routine oral medication prior to the client's hospitalization in August, 2014, and upon discharge, was not included in the discharge instructions. The client's Dr. was contacted and instructed the agency RN to continue the medication. The order stayed on the MAR as "PO".	
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9 107	Continued From page 3 1) self-feeding for Client #3; 2) follow health and safety instructions regarding height of hospital bed for Client #3; 3) reporting medication order discrepancies and following physician orders; and 4) implementing the health and safety instructions for flushing the G-tube after medication administration.	9 107	documentation of the Physician's 90-day Orders for all clients in the Residence and submit the orders to the Program Supervisor who will review for accuracy for a period of one year. The Resident and Day Program Managers will observe and document three (3) times weekly for a period of two (2) months, the correct implementation of the Five Rights of medication administration including the requirement to report all discrepancies. Documentation will be reviewed by the Program Supervisor and located in the QA binder. 4) Implementing the Health & Safety instructions for flushing the G-tube after medication administration for one client: To correct this issue, a thorough review of the one client in the home with a G-Tube procedure was reviewed and determined to be adequate. However, one staff's implementation of the procedure in the Day Program was insufficient. Staff # 1 was retrained by the agency RN on the correct procedure for flushing the G-tube after medication administration and prior to feeding. There is only one client with a G-tube in the Residence. To ensure no other staff implements the G-Tube procedures incorrectly, all staff in the Residence	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
9 172	Continued From page 4 2) The procedure for flushing the G-tube after administering medications was not followed. Observation during medication administration on the morning of 1/6/15 had the licensed nurse administering three medications to Client #2 through a G-Tube. After the medications were administered and without flushing with water, she proceeded to administer a bag of enteral nutrition (formula) to the client. Interview with the Registered Nurse (RN) on the afternoon of 1/6/15 confirmed that after medications are administered through the G-tube a water flush should be done before proceeding to administer the enteral nutrition through the G-tube. She provided a document titled "Health and Safety Instructions" for Client #2. It stated under the section Administering medication through G-tube "6. ALWAYS FLUSH G-TUBE WITH AT LEAST 30-40 ML OF WATER after medications are given." The RN confirmed that the G-tube had previously become clogged and as a result she had instructed the staff to crush the medications finely and flush the tubing with water. 3) During an observation in the home on the afternoon of 1/6/15, Client #3's hospital bed was in a high position and he was sleeping unattended in his room. Observation of Client #3 in his bed during lunch on 1/6/15 had the bed in a low position. However, observation on the afternoon of 1/6/15 had Client #3 sleeping on his bed with the bed in a high position. He was alone in his room and his eyes were closed. An evening staff was asked as to why the bed was raised in a high position. She stated that the client likes to look out the window so the bed remains in the high position so he can	9 172	**The facility did not ensure that nursing services must include other nursing care as identified by client needs for 2 clients. (Clients #2 and #3)** 1) Medication error for Client #2: (See Reference Tag ID 9 107 #3 above) 2) Procedure for flushing G-tube for Client #2: (See Reference Tag ID 9 107 #4 above) 3) Hospital bed in a high position for Client #3: (See Reference Tag ID 9 107 #2 above)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	12G038	A. BUILDING: _____ B. WING _____	01/07/2015

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9 172	Continued From page 5 look out the window. It was brought to the staff's attention that the client was sleeping, and the response from the staff was it remains in the high position as he may wake up. Record review found a document titled "HEALTH and SAFETY INSTRUCTIONS... Revised 10/29/14". It was noted under "C" for Sleeping: that the client has a hospital bed. "The bed is to be raised to staff waist level for any incontinence care that is done while Client is in bed. Lower the bed to its lowest position when care is complete." Interview on 1/6/14 with the facility RN confirmed that she had assessed, written and updated the client's health and safety plans. She reported that she did give staff permission to leave the bed up as the client enjoyed looking out of the window. She added that the crank style bed made it challenging for the staff to raise and lower the bed.	9 172		
9 191	11-99-22(e) PHARMACEUTICAL SERVICES Only appropriately trained staff shall be allowed to administer drugs and shall be responsible for proper recording of the medication, including the route of administration. Such persons shall have satisfactorily completed a course of training in the administration of drugs, which course has been approved by the Department. Medication errors and drug reactions shall be recorded in the resident's chart and reported immediately to the physician who ordered the drug and an incident report shall be prepared. All incident reports shall be kept available for inspection by the	9 191	**Reference Tag ID 9 191** **11-99-22 (e) PHARMACEUTICAL SERVICES** **The facility did not ensure that the system for drug administration assured that all drugs are administered without error.** (See Reference Tag ID 9 107 #3 and Reference Tag ID 9 172 #1 above)	2/4/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	12G038	A. BUILDING _____ B. WING _____	01/07/2015

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9 191	Continued From page 6 Director. This Statute is not met as evidenced by: Based on observation, interview, and record review, the facility did not ensure that the system for drug administration assured that all drugs are administered without error. Findings include: Cross reference to W368. Observation during medication administration on the morning of 1/6/15 had the licensed nurse administering medications to Client #2 through a G-Tube. The label on one of the medications administered was for Clindamycin HCL 150 mg., 2 capsules (300mg). The nurse administered the medication by opening the capsule, and dissolving the contents in warm water. Another error occurred when she administered Clonidine HCL 0.1 mg po tid., which she crushed and placed in the warm water. The medications were administered through the G-Tube.	9 191		